

**MINNESOTA OFFICE OF PIPELINE SAFETY
INTRASTATE ANTI-DRUG and ALCOHOL MISUSE PREVENTION
SELF-ASSESSMENT FORM**

Date: _____

Operator's IOCS ID: _____
(To be filled in by MnOPS)

Inspection Unit's IOCS ID: _____
(To be filled in by MnOPS)

Operator's Name: _____

Name/Title of Person Responsible for Completing This Form: _____

Company Address: _____

Company Telephone No.: (_____) _____

Type of Facility _____ Gas Transmission _____ Hazardous Liquid Pipeline
 _____ Gas Distribution _____ Liquefied Natural Gas

Anti-Drug and Alcohol Misuse Plan/Policy Developed by: _____
(Name of individual or company)

Anti-Drug and Alcohol Misuse Testing Program Administered by: _____
(Name of individual or company)

Contractor's Records Maintained by: _____
(Name of individual or company)

Specimen Collection Conducted by: _____
(Name of individual or company)

Breath Alcohol Test Conducted by: _____
(Name of individual or company)

I, the undersigned, certify that the information provided on this Minnesota Office of Pipeline Safety, Anti-Drug and Alcohol Misuse Prevention Self-Assessment Form is, to the best of my knowledge and belief, true, correct, and complete.

Signature

Date of Signature

Title

(_____) _____
Phone Number

NOTE: If any question on the following self-assessment form is answered by other than a "YES" response, please identify the question and explain in the "COMMENTS" area at the bottom of the page, or attach an additional sheet.

§§199.1, 199.200 and §40.1		COMPLIANCE	
1. Is your company continuing to comply with the drug and alcohol testing regulations as required under 49 CFR Parts 199 and 40?		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
§§199.7 and 199.202		COMPLIANCE	
1. Is your company continuing to maintain written anti-drug and alcohol misuse prevention plans?		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
2. Have there been any significant changes to the policy/plans? <i>Please provide MnOPS with a copy of any changes.</i>		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
<p align="center">PLEASE PROVIDE THE NAME, ADDRESS AND PHONE NUMBER OF THE FOLLOWING: USE AN ADDITIONAL SHEET OF PAPER IF NECESSARY.</p>			
§§199.7, 199.11 and §40.33		MEDICAL REVIEW OFFICER(s)	
Name: _____		Phone Number: (____) _____	
Address: _____		_____	
_____		_____	
_____		_____	
§199.243		SUBSTANCE ABUSE PROFESSIONAL(s)	
Name: _____		Phone Number: (____) _____	
Address: _____		_____	
_____		_____	
_____		_____	
§199.13 and §§40.25, 40.29 and 40.39		DRUG TESTING LABORATORY(s)	
Name: _____		Phone Number: (____) _____	
Address: _____		_____	
_____		_____	
_____		_____	
§§199.19 and 199.243		EMPLOYEE ASSISTANCE PROGRAM(s)	
Name: _____		Phone Number: (____) _____	
Address: _____		_____	
_____		_____	
_____		_____	

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1. Does your company monitor those contractors and subcontractors who perform functions covered by the drug/alcohol plan?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
2. Has the method of contractor monitoring changed? <i>If so, please specify what changes were made.</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
§§199.23 and 199.227	COMPLIANCE
1. Are all drug/alcohol records maintained in a secure location?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
2. By Whom: Operator/Service Provider/Contractor Name: _____ Phone Number: (____) _____	
§§199.25 and 199.229	COMPLIANCE
1. Has your company maintained the necessary MIS data sheets?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
2. Who maintains the data? Name: _____ Phone Number: (____) _____	
§§40.51 and 40.93	
1. Who supplies your company's trained Breath Alcohol Technicians and Screening Test Technicians? <i>(Use an additional sheet of paper if necessary.)</i> Service Provider's: Name: _____ Phone Number: (____) _____	
§§40.53 and 40.91	COMPLIANCE
1. Does your company only use devices listed on the Conforming Products List?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
2. Please provide the name, model and serial number of the device(s) used. Name: _____ Model: _____ Serial No.: _____	

COMMENTS

SECTION INITIALLY LEFT BLANK FOR UPDATES/CHANGES IN CODES